Mid-Staffordshire

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DOI:
10.1111/1467-923X.12698

The Political Quarterly, Vol. 90, No. 2, April–June 2019

Mid Staffordshire: a Case Study of Failed Governance and Leadership?

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Abstract
The public inquiry chaired by Robert Francis QC into failings of care at the Mid Staffordshire NHS Foundation Trust made 290 recommendations about matters including: standards of patient care in the National Health Service (NHS); organisational culture and leadership; the use of data and information; the need for greater openness; and compassionate and committed nursing. In this paper, we argue that Mid Staffordshire represented a profound failure of governance and leadership. We use findings from a national research study to analyse the response made by the boards and leadership of NHS hospitals to the inquiry recommendations, setting out the repertoire of board roles and behaviours required for the governance of safe and effective care.

Keywords: public inquiries, healthcare boards, healthcare governance, Francis inquiry, leadership

Background

IN 2013, Sir Robert Francis QC published the report of the public inquiry into Mid Staffordshire NHS Foundation Trust, setting out his conclusions about the failings in care which occurred at Stafford Hospital between 2005 and 2009.[1] The events in Stafford had been brought to light initially through the sustained efforts and campaigning of a patient and carers' group called Cure the NHS, and included many cases of shockingly poor nursing and medical care, particularly for older people and those who were dying, and also those treated in the hospital's accident and emergency department. Details of the failings in care had been set out in a prior independent inquiry report also written by Robert Francis, and the founder of Cure the NHS, Julie Bailey, wrote her excoriating account of what happened at Stafford Hospital in a book *From Ward to Whitehall: the Disaster at Mid Staffs Hospital*.[2,3] The public inquiry was established in 2010 by the incoming coalition government explicitly to explore 'the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role … and to examine why problems at the Trust were not identified sooner; and appropriate action taken'.[4]

The report of the public inquiry, the Francis report, set out 290 recommendations for various parts of the NHS at a local, regional and national level, and other recommendations for a wide range of national regulatory and professional bodies including the Health and Safety Executive, Care Quality Commission, and the Department of Health. The recommendations were grouped into six themes: common values; fundamental standards; openness, transparency and candour; compassionate, caring and committed nursing; strong patient-centred leadership; and accurate, useful and relevant information. Some of the specific recommendations that have subsequently been implemented in the NHS include: regular monitoring and public reporting of safe staffing standards in hospitals; the requirement that clinicians and managers work with a 'duty of candour' towards patients and relatives, being honest and up front when mistakes have been made and/or harm has occurred; the establishment of an NHS Leadership Academy to design and deliver training and development to NHS clinicians and managers about patient-

centred leadership; and extensive work to improve the nature, operation and effectiveness of patient complaints procedures.

Governance and leadership at Stafford

One of the most frequently heard questions about the events at Stafford Hospital is 'how on earth was this able to happen?'. The sheer number of patients, families and hospital staff (those who became 'whistleblowers') reporting poor care, and over such an extended period of time, appears astonishing in the context of a publicly funded national health system in a major developed nation. Robert Francis' overall diagnosis of Stafford was that there was 'A culture focused on doing the system's business—not that of the patients.'[5] He pointed to a lack of compassion amongst hospital staff, noting that many of them were disengaged from the organisation, keeping quiet as they feared getting into trouble. Francis also highlighted a failure on the part of many professional and patient groups (not Cure the NHS) to think sufficiently about the needs of patients, and a concern that regulators appeared to miss what was most important for patients and their families. Indeed, Francis identified over fifty occasions where different health organisations missed opportunities to spot and act upon the events that were taking place at Stafford Hospital. This all begs a very profound question about what had gone wrong with the governance and leadership at Stafford.

Stafford Hospital was in many respects an isolated organisation, situated on the periphery of the NHS' West Midlands and North West Regions. As a district general hospital —one of many built in the late 1960s and early 1970s following publication of Enoch Powell's *Hospital Plan* and typically in rural shire counties or on the outer rim of major conurbations—Stafford was trying to provide a comprehensive range of local health services, yet struggling to attract and retain sufficient senior and specialised clinical staff, and keep core facilities such as its accident and emergency department open on a twenty-four-hour basis.[6] It was not sufficiently networked with major teaching hospitals, and performance management of the organisation (the NHS foundation trust) was found by the Francis inquiry to be inadequate. All of this arguably contributed to the pressure faced by those working in, and seeking to lead and govern, Stafford Hospital.

A further factor contributing to the weakness in governance and leadership of Stafford Hospital was the nature of its management team. The chief executive was in his first such role—district general hospitals (DGHs) are often considered appropriate as 'first step' chief executive roles, but given the complexity and isolation of some such hospitals as outlined above, leading a DGH is arguably one of the toughest roles in the NHS. The wider executive team of Stafford Hospital was described by the Francis report as being out of touch with patient and carer experience, and disconnected from the priorities and concerns of frontline staff. Indeed, the board of the hospital trust seemed more preoccupied with looking upwards to regulators and performance management bodies (for example, pursuing the elite 'foundation trust' status on offer to high performing NHS organisations and achieving national waiting time and financial targets) rather than looking inwards to its staff, patients and clinical services, or outwards to the population of Stafford.

Some critics of the public inquiry argue that Francis stopped short of pinning the blame for failures of care on any one person or organisation. This was not in fact true. On the day that the inquiry report was published in London, Francis said in his public statement: 'What brought about this awful state of affairs? The trust board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities.'[7]

As well as the board, there was a wider failure of governance at Stafford Hospital that contributed to the sustained lack of attention to the many examples of inadequate care, disengaged staff, and unnecessary deaths. There were many who held formal governance roles who just did not seem to notice what was unfolding at

Stafford, or if they did, failed to act on what they saw or heard. For example, NHS commissioners were funding care at Stafford as part of contracts that set out quality standards; senior doctors were undertaking a clinical audit of services in their hospital, and all clinicians in the trust were subject to professional codes of conduct which require the reporting of poor treatment of patients; universities and deaneries were assessing Stafford as fit for training medical, nursing and other students; local government scrutiny bodies failed to see the full picture; and Monitor, the regulator, approved Stafford for foundation trust status—a decision that was signed off by the Secretary of State for Health. It should be noted, however, that it was the NHS regulator the Healthcare Commission that eventually blew the public whistle on Stafford in a report published in 2009, responding to concerns put to them by Cure the NHS.

The conundrum of 'culture'

As with many other NHS public inquiries over the past fifty years, for example the 2000 Bristol inquiry into paediatric heart surgery, 'culture' was identified by Francis as being problematic at Stafford and something needing to be attended to if such failures of care were to be avoided in future. When discussing his public inquiry report after its publication, Francis suggested that the negative culture he identified at Stafford was formed of a toxic mix of pressure (for example, targets, financial troubles), negative reactions to such pressure (such as fear, low morale, disengagement), resulting poor behaviour on the part of staff (for example, uncaring, bullying, keeping one's head down), and then such behaviour becoming habitual (as in tolerating poor standards of care, denying problems, and taking comfort from erroneous external reassurance).[8] Francis presented this series of cultural dimensions as interconnected within a closed circle. This was very reminiscent of the 'club culture' described by Sir Ian Kennedy in his report of the Bristol inquiry based on analysis by Smith and Ham of a hospital's culture where the prevailing atmosphere was one of fear and blame: you were either in or out, and were not expected to 'rock the boat' in any way, and especially not by blowing the whistle on poor performance.[9]

Reflecting on the Francis report in a manner that resonates very clearly with the inquiry chair's own analysis of what needed to be done to try and address the conundrum of organisational culture, Newdick and Danbury pointed to four issues that they considered to be critical. First, a need to strengthen patients' voice and influence within the NHS, arguing that mechanisms for patient involvement are deeply inadequate and nowhere near as effective as the former community health councils abolished in England in 2003, although it should be noted that they continue to exist in Wales. Second, Newdick and Danbury underline the importance and value of the duty of candour that Francis proposed for the NHS (and which was accepted by the Department of Health and enshrined in statute). Their other two themes are interrelated, being those of NHS managerial culture with a relentless focus on good news and denying failure, and then the Department of Health and political centre's sometimes overbearing treatment of NHS managers and boards.[10] These four dimensions have been analysed by the Francis inquiry's adviser on NHS organisation as having the potential to create damaging and negative health leadership culture, and when positive and appropriately focussed, to enable a positive, supportive, and compassionate working environment and context.[11]

This analysis in 2013 concluded with the following: 'Get serious about strengthening patient voice at a local level in the NHS, implement a duty of candour with legal backing, support managers and boards to prioritise quality alongside their financial and other duties and make sure the political centre treats NHS organisations and leaders in a mature and respectful manner.'[12] This begs the vitally important question as to what has happened to NHS governance and leadership in the six years following publication of the Francis report. Have the much vaunted changes to organisational and managerial culture started to occur? Is patient voice stronger than it was, and critically, are NHS boards feeling emboldened to prioritise quality and safety of care alongside or even over financial duties?

What happened next?

To answer these and other questions about what happened following the publication of the Francis report, and the setting out by the Department of Health of its formal response and planned actions in *Hard Truths: The Journey to Putting Patients First*, the National Institute of Health Research (NIHR) commissioned a set of research studies in 2015, through its Policy Research Programme.[13] One of these studies focussed on changes in board leadership of NHS organisations following the Francis inquiry, and was commissioned from the Universities of Manchester and Birmingham, and the Nuffield Trust and undertaken by the authors of this paper and others.[14] The research—which forms the basis of the analysis set out in this paper—aimed to explore how boards and senior leaders of NHS acute hospital trusts had sought to implement the recommendations on organisational leadership made following the Francis report, and to examine the intended and unintended effects of this. Furthermore, the research aimed to uncover the enablers and barriers to improving senior leadership, and hence wider board and organisational culture in the NHS, in the context of the often toxic and unhealthy management cultures described in Bristol and Stafford, among other inquiries.

In scoping the research study, interviews were undertaken with national health policy opinion leaders to elicit their views about the desirable characteristics of healthcare boards. This built on a review of the academic literature in this area and resulted in the dimensions set out in Table 1.

The depiction of board characteristics in Table 1 is stark in how the dimensions of board behaviours diverge from what was found and reported in the reports of the public inquiries in Bristol and Stafford. In particular, they differ in their focus on restless curiosity, the use of data to ask important questions about quality and safety, and being assiduous in remaining very well connected to the concerns and priorities of patients, families, and staff, as well as to (and certainly not in preference to) national health regulators. This articulation of healthy board behaviours framed the NIHR study of board behaviours and leadership following the Francis report, and was used as the basis for a national survey of board members of NHS hospital trusts in 2016, and the development of a set of six in-depth case studies of hospitals where their board and wider leadership behaviours and culture were examined in depth in 2016–2017.

Table 1: Desirable characteristics of NHS boards, as reported by national opinion leaders in Chambers et al., 2018

- Are palpably focused on patient care
- Give priority to quality, safety and learning for improvement
- Are more problem-sensing than comfort-seeking
- Know what is going on, for example worries of patients, staff and regulators
- Receive timely data on patient and staff concerns
- Hardwire quality improvement through the organisation
- Support staff, heed concerns, and protect staff from negative pressures
- Promote a healthy, compassionate and well-governed culture
- Use data and information as the basis for improvement

The national survey of board members of NHS hospital organisations in 2016 elicited 381 responses, covering 90 per cent of NHS acute services trusts. The findings of this survey are perhaps best summed up by a quotation drawn from a free text response in the survey, made by an NHS non-executive director: 'The Francis report has acted as a reminder of what sort of organisation we don't want to be like, and continues to be a reminder'. The survey revealed that following the publication of the Francis report in 2013, NHS organisations had developed—or revised and extended—a raft of policies including those relating to the handling of patient complaints, serious incidents, seeking patient feedback, and staff engagement. Indeed, whilst many board members reported significant efforts to improve patient and carer experience, and the engagement of staff, it was salutary to discover that respondents to the survey

admitted that they knew more about what was important to national regulators of the NHS than they did about the priorities and concerns of patients and staff. In this way, it was clear that the overbearing nature of NHS management culture highlighted by Kennedy (in the Bristol inquiry) and Francis was still alive and kicking—almost literally in some cases—and that NHS hospital boards found themselves compelled to look upwards to regulators more frequently than inwards to their patients and staff.

When asked in the research survey about the main challenges facing their organisation, hospital board members identified: patient safety, trying to achieve financial balance, dealing with the demands of regulators, seeking to cope with workforce shortages and having to navigate poor relationships in the local health economy. Indeed, a central theme emerging in the research was the profound dilemma and tension experienced by hospital boards in trying to balance care quality and safety on the one hand, and financial sustainability on the other. Whilst the Francis report had led hospital boards to make significant investments in nurse staffing levels on wards and in emergency departments, and many had also recruited additional doctors to try and ensure patient safety and care, it was clear that three years on from the inquiry publishing its conclusions, the NHS was struggling to hold this line. Increasing financial austerity across the public sector was being felt by NHS boards, who, having invested in staff to address known points of stress and vulnerability for patient safety, were now feeling pressure from above to stay within budget whilst coping with a rising demand for services.

Thus, the research survey painted a picture of NHS hospital boards that had largely regarded the Francis report as instructive, timely and helpful. These boards had responded to the report by increasing staffing levels in critical areas of their hospital, ensuring that the 'duty of candour' (for all clinical staff in the NHS to be frank and open with patients and families when something has gone wrong) recommended by Francis had been fully implemented, and working hard to ensure that their organisation was 'well-led' as required by the new standards for governance and leadership established by the Care Quality Commission following the Francis inquiry. As noted above, attention had been paid to improving policies about patient complaints and staff engagement, and finding ways to partner with other organisations to try and improve patient care. The Francis report had clearly pricked the conscience of most NHS organisations about the perils of letting care quality and safety fall off a board's radar, with some stating in the research that 'there but for the grace of God go others of us'.

What was clear from the research was that many NHS hospital board members were exercising leadership that—following the Francis report—appeared to be more visible to staff and patients. Quality was reported by a majority of board members to trump finance on occasions where 'push came to shove'—something that was felt to have been given validity and even authorisation by the findings and response to the Francis inquiry. Related to this, the research identified a rise in the influence of the chief nurse on NHS boards, their voice being considered more influential and powerful, particularly in relation to matters of care quality and patient safety. Furthermore, and unsurprisingly, it was found that a board with stability of membership and lower turnover appeared to help it work in a unitary, and yet healthily challenging, manner. Finally, the research study revealed that those hospitals with 'outstanding' or 'good' overall ratings from the Care Quality Commission had higher self-reported scores for emphasising a full range of board purposes, including: holding to account; supporting the executive team; building organisational reputation; seeking and acting on the views of a wide range of stakeholders; and being effective in reconciling the views of competing interests.

How can the NHS have healthy governance and leadership?

The Francis report revealed an organisation in Stafford that had completely lost its way in relation to its governance and leadership, with tragic consequences for many patients, family and staff. The board of the hospital was out of touch with what really mattered, namely the quality and safety of patient care, the

concerns and needs of those using the hospital's services, and the pressures on staff which, in turn, were fuelling an organisational culture that in many areas was becoming toxic, fearful and even dangerous. The research undertaken by the team from the Universities of Manchester and Birmingham showed encouraging progress across the NHS in some aspects of the inquiry's recommendations.

The climate in which the NHS is operating has, however, become more difficult since the publication of the Francis report in 2013. The National Audit Office has reported that the combined deficit of health service provider organisations in 2017–18 is £991 million; staff vacancy levels across the NHS are running at around 100,000. Significant variation in the accessibility, quality and patient-centredness of care, in levels of staff morale, and leadership capacity and capability, all persist and are now evidenced in Care Quality Commission inspection findings. NHS trusts face multiple, simultaneous and seemingly conflicting demands of ensuring financial balance, overcoming workforce shortages, capitalising on the opportunities of new technologies, dealing with the pressures of population ill-health, and coping with the fragility of the social care sector—all of which add up to the need for a massive change effort. There is also an unpredictable wider political and social set of conditions: Brexit, populism, social media to name a few. We are living in an uneasy age.

Given this challenging context, the analysis of the leadership changes made by NHS hospital boards, and the reported behaviours, reasoning and responses of participants in the research study, we suggest five key roles for healthcare boards. Set alongside our understanding of theories about effective healthcare board governance, we also propose a repertoire of associated dyadic behaviours for board members to adopt.[15] Drawing from our analysis of findings from the empirical study, the five roles we propose are: the board as conscience, shock absorber, diplomat, sensor and coach. These roles and behaviours are summarised in Table 2 below.

What then does this suite of roles and behaviours comprise for hospital boards who are seeking to provide effective leadership to their organisation? First, in relation to the role of the board as conscience of the organisation, NHS boards need to own the legacy of the Francis inquiry in respect of upholding fundamental standards of care, and the principles of the NHS constitution even when the external context makes it difficult to do so. This role of being the conscience of the organisation includes leading the development of a core set of values, deliberative and inclusive approaches to developing strategy and making priority-setting decisions, and using listening and questioning behaviours.

Second, a recurring theme in research into NHS boards is the burden of external regulation and an often frenetic policy environment where new initiatives can appear to shower down upon hospitals and their leaders. In these circumstances, boards need also to act as a shock absorber for their staff. This means absorbing the attention and challenge of multiple external bodies, probing where necessary, distilling the feedback into

Table 2: Proposed repertoire of roles and associated behaviours of NHS boards in the wake of Francis, Chambers et al., 2018

Role	Behaviours
Conscience: *upholding the organisation's mission and the values of the NHS*	Listening and questioning
Shock Absorber: *supporting staff in adverse circumstances and through difficult times*	Courageous and probing
Diplomat: *understanding and acknowledging different internal and external interests and perspectives*	Ambassadorial and curious
Sensor: *using diverse sources of data to detect and solve local problems*	Challenging and supportive
Coach: *setting ambitious aims, benchmarking services, and seeking continuous quality improvement*	Mentoring and inquiring

messages that can be used to guide and support changes, and sheltering staff from unhelpful external 'noise'. As the director of organisational development at one of the case study sites in our NIHR research study put it, 'to filter all the nonsense that comes from the outside'. This can include the adoption of appropriately courageous and probing behaviours when communicating with external national bodies.

Third, we identified the role of the board as diplomat. This includes promoting the reputation of the organisation using ambassadorial type behaviours. But it also entails having the curiosity and empathy to understand and acknowledge the full range of internal and external stakeholder interests and perspectives, and knowing how to relate to other providers and operate within the local health and care economy. As a board secretary described it in our national survey: 'Although the relationships with others in the local economy could not be said to be "poor", they are not necessarily helpful. What is lacking is system leadership to try to overcome individual agendas and encourage collective thinking and action for the benefit of patients.'

Fourth is the role of the board as sensor, having more of a problem-sensing than a comfort-seeking orientation when scrutinising, with skill and wisdom, an appropriate range of information, including qualitative feedback on patient and staff experiences, as well as maintaining a focus on key performance indicators. In working with managers and staff in the pursuit of better and safer care, this includes exhibiting both challenging and supportive behaviours.

Finally, with the imperative for service improvement and striving for excellence to ensure sustainable and clinically effective care, it is clear that boards also have a valuable role as coach, using the analogy of the sports coach. This involves setting ambition and direction, assessing performance, and supporting staff, in an inquiring, mentoring and collaborative way. In the research study described above, this role is best likely to be fulfilled when there is visibility, stability and continuity in board membership, and board members are appropriately trained and developed.

It is clear from this research that a whole range of issues need to be contemporaneously handled or resolved by the leadership of NHS organisations—this requiring multiple skills that are constantly held in tension—to enable the work of the board to be achieved in an appropriately sensitive and effective manner.[16] The dyadic sets of board behaviours are presented in this paper as a way of understanding how some of these paradoxes and tensions faced by healthcare boards can be managed in an appropriate and robust manner. For example, this may entail a board confronting the possibility of closing a popular local service which it knows is not (and cannot be made to be) clinically safe. These board behaviours can be understood further within the theoretical framework of board governance and leadership developed in prior work by Chambers et al.[17]

Thus it can be understood that board members face choices in different situations about how to deploy their repertoire of leadership behaviours. In the circumstance of a board having a low appetite for risk, in its role of sensor it will need to seek out truths about performance. Then, using an agency theoretical frame, the board's dominant mode of behaviour is likely to be challenging but also supportive, to ensure management is not driven to hide unpleasant facts about performance. In circumstances which call particularly for a coaching role to encourage collective innovation, improvement and striving for excellence, the likely dominant behaviours of the board will be collaborative and inquiring, drawing from a stewardship theoretical perspective. In circumstances when the organisation needs to build a better external reputation and improved local relationships, we would argue that the board has to prioritise its role as diplomat, and behaviours which demonstrate curiosity and ambassadorship are called for. A focus on high levels of staff engagement and long-term organisational sustainability indicates the importance of representation, collective effort and sharing of risks, and the board as the conscience of the organisation, with listening and questioning behaviours coming to the fore to reflect the stakeholder perspective. Finally, the board, acting as shock absorber to ensure an internal and external equilibrium of power interests, will need to be both probing and courageous. Their responses to the Francis inquiry report as explored in our research for the NIHR demonstrated some of this.

Conclusion

The legacy of the Francis inquiry has indeed been identified in some beneficial impacts on the intentions and behaviours of senior hospital managers and their boards. There continues, however, to be concern about variation in the quality and consistency of such leadership practices and in the current circumstances, courage and diligence are required to create a climate and culture for kind, safe and clinically effective patient care. The deployment of a comprehensive NHS board and senior leadership repertoire of roles and behaviours to mirror the complexity of the management task and the trickiness of the external environment is required.

We make a case for the difference that the dynamic and restless NHS board can make, if the failings of governance and leadership revealed by the Francis inquiry are to be avoided in the future. This builds on the work of board governance scholars who have exposed the gap between the myths and the realities of the work of boards in all sectors, the variable discretionary effort of board members, and the impact of minimalist and maximalist board practices.[18] In addition, our proposed board leadership repertoire reflects the notion that the lived experiences of senior leaders in the NHS and the ongoing challenges they face cannot be fitted neatly into traditional theoretical governance categories. Switching from one mode of behaviour to another according circumstances may be important, but so too is the ability to deploy fully, across time, the roles of the diligent board. Only if this happens will we be able to assert that the chances of 'another Stafford' have been reduced.

Notes

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